Washington State Department of Health

ATTENDING PHYSICIAN'S COMPLIANCE FORM

MAIL FORM TO: State Registrar, Center for Health Statistics,
P.O. Box 47856, Olympia, WA 98504-7856

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
MEDICAL DIAGNOSIS	

B PHYSICIAN INFORMATION

NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
MAILING ADDRESS	
CITY, STATE AND ZIP CODE	

C ACTION TAKEN TO COMPLY WITH LAW

1. FIRST ORAL REQUEST

First oral request for medication to end life. | DATE

Comments:

Indicate compliance by checking the boxes. (Both the attending and consulting physicians must make these determinations.)

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination the patient has six months or less to live.
- ☐ 3. Determination that patient is competent.*
- ☐ 4. Determination that patient is a Washington state resident.**
- ☐ 5. Determination that patient is acting voluntarily.
- 6. Determination that patient has made his/her decision after being fully informed of:
  - ☐ a) His or her medical diagnosis; and
  - ☐ b) His or her prognosis; and
  - ☐ c) The potential risks associated with taking the medication to be prescribed; and
  - ☐ d) The potential result of taking the medication to be prescribed; and
  - ☐ e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

Indicate compliance by checking the boxes. | DATE:

- ☐ 1. Patient informed of his or her right to rescind the request at any time.
- ☐ 2. Patient recommended to inform next of kin.
- ☐ 3. Patient counseled about the importance of having another person present when the patient takes the medication(s).
- ☐ 4. Patient counseled about the importance of not taking the medication in a public place.

2. SECOND ORAL REQUEST (*Must be made **15 days** or more after the first oral request.*)

Indicate compliance by checking the boxes. | DATE:

- ☐ 1. Second oral request for medication to end life.
- ☐ 2. Patient informed of the right to rescind the request at any time.

Comments:

ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

C ACTION TAKEN TO COMPLY WITH THE LAW – continued

3. PATIENT'S WRITTEN REQUEST

☐ Written request for medication to end life received. Please attach request. (*No less than **48 hours** shall elapse between the written request and writing the prescription*.)	DATE
Comments:	

D MEDICAL CONSULTATION (Attach consultant's form.)

Medical consultation and second opinion requested from:

MEDICAL CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

E PSYCHIATRIC/PSYCHOLOGICAL EVALUATION

*Check one of the following **(required)**:*

☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in accordance with chapter 70.245 RCW.

☐ I have referred the patient to the provider listed below for evaluation and counseling for a possible psychiatric or psychological disorder, or depression causing impaired judgment, **and attached the consultant's form**.

PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER ( ) —	DATE

F MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT

(*To be prescribed no sooner than **48 hours** after patient's written request has been signed*.)

LETHAL MEDICATION PRESCRIBED AND DOSE	DATE PRESCRIBED

Please check one of the following:

☐ Dispensed medication directly. Date ____/____/____

☐ Contacted pharmacist and delivered prescription personally or by mail to the pharmacist.

Pharmacy Name City Phone # **( ) -**

Immediately prior to writing the prescription, the patient was fully informed of: (*check boxes*)

☐ (a) his or her medical diagnosis;

☐ (b) his or her prognosis;

☐ (c) the potential risks associated with taking the medication to be prescribed;

☐ (d) the probable result of taking the medication to be prescribed;

☐ (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

To the best of my knowledge, all of the requirements under the Washington Death with Dignity Act have been met.

X	PHYSICIAN'S ORIGINAL SIGNATURE	DATE

* "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

** Factors demonstrating residency include, but are not limited to: 1) Possession of a Washington state driver's license; 2) Registration to vote in Washington state; 3) Evidence that a person owns or leases property in Washington state.